

EXHIBIT A

**UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK**

JEFFREY FARKAS, M.D., LLC,

Plaintiff,

-against-

LEADING EDGE ADMINISTRATORS,

Defendant.

Index No.:

COMPLAINT

Plaintiff, Jeffrey Farkas, M.D., LLC (“Plaintiff”), on assignment of Temuri C., by and through its attorneys, Schwartz Sladkus Reich Greenberg Atlas LLP, by way of Complaint against Defendant, Leading Edge Administrators (“Defendant”), alleges as follows:

PARTIES, JURISDICTION, AND VENUE

1. Plaintiff is a New Jersey limited liability company with a principal place of business at 43 Westminster Avenue, Bergenfield, New Jersey 07261.
2. Upon information and belief, Defendant is engaged in administering health care plans or policies in the state of New York.
3. Jurisdiction is proper in this Court pursuant to 28 U.S.C. § 1331 and 29 U.S.C. § 1132(e). The insurance policy at issue is governed by the Employee Retirement Income Security Act (“ERISA”), 29 U.S.C. § 1001 *et seq.* The administrative remedies have been exhausted.
4. Venue is proper in the United States District Court for the Southern District of New York based upon Defendant’s residence.

FACTUAL BACKGROUND

5. Plaintiff is a medical provider comprised of a team of neurologists who specialize in acute treatment following strokes, brain aneurysms, carotid disease, and vascular problems of the brain, spine, and neck.

6. Plaintiff's doctors perform major brain surgery in emergency, and often lifesaving, situations.

7. On November 22, 2016, November 23, 2016, and November 24, 2016, Plaintiff performed a series of emergency evaluations and surgical procedures on Temuri C. ("Patient") who was suffering from carotid artery stenosis. (*See, Exhibit A*, attached hereto.)

8. At all relevant times, Patient was the beneficiary of an employer-based health insurance plan for which Defendant served as claims administrator.

9. Patient assigned his applicable health insurance rights and benefits to Plaintiff. (*See, Exhibit B*, attached hereto.)

10. Pursuant to the assignment of benefits, Plaintiff submitted Health Care Financing Administration ("HCFA") medical bills to Defendant seeking payment for the medical services provided to Patient in the total amount of \$144,375.02. (*See, Exhibit C*, attached hereto.)

11. As an out-of-network provider, Plaintiff does not have a network contract that would determine or limit payment for Plaintiff's treatment of Patient.

12. In response to Plaintiff's HCFA medical bills, Defendant issued payment in the total amount of \$5,955.41, leaving an outstanding balance of \$138,419.61.

13. Defendant's explanations of benefits ("EOBs") indicate that the unpaid portion of Plaintiff's charges were left unpaid pursuant to a provider discount even though Plaintiff never agreed to any such discount. (*See, for e.g., Exhibit D*, attached hereto.)

14. Defendant's EOBs further include a "reason code" next to the provider discount. The code listed under the reason code column is "755." *Id.*

15. The bottom of Defendant's EOBs include a description of reason code 755 stating as follows: "THE AMOUNT REPRESENTS THE DIFFERENCE BETWEEN THE PROVIDER'S CHARGES AND THE OUT OF NETWORK ALLOWED AMOUNT. THE MEMBER IS RESPONSIBLE FOR THIS AMOUNT." *Id.*

16. However, the reason code is contradicted by the "patient responsibility" portion of the EOB which conspicuously notes the patient's responsibility to be \$0.00. *Id.*

17. Moreover, upon information and belief, under the terms of Patient's insurance plan, out-of-network emergency treatment must be reimbursed in a way that exposes Patient to no greater liability than he would be exposed to had he utilized a network provider.

18. Thus, under the terms of Patient's insurance plan, Defendant was obligated to issue reimbursement for the subject medical services pursuant to Plaintiff's billed charges, or alternatively, pursuant to a payment rate agreed upon by Plaintiff.

19. By indicating in its EOB that Plaintiff accepted a "provider discount", Defendant was in effect representing that it processed Plaintiff's claims correctly under the terms of Patient's insurance plan.

20. However, since Plaintiff never agreed to any provider discount, Defendant did not process Plaintiff's claims correctly under the terms of Patient's insurance plan.

21. Because Defendant did not properly process Plaintiff's claims, Patient submitted multiple internal appeals to Defendant, challenging Defendant's reimbursement under the terms of Patient's insurance plan.

22. However, Defendant failed to issue any additional reimbursement in response to Patient's internal appeals.

23. As a result of Defendant's failure to issue reimbursement for Patient's treatment in accordance with the terms of his insurance plan, Plaintiff has been damaged in the amount of \$138,419.61.

24. Accordingly, Plaintiff brings this action for recovery of the outstanding balance, and Defendant's breach of fiduciary duty.

COUNT ONE

FAILURE TO MAKE PAYMENTS PURSUANT TO MEMBER'S PLAN UNDER 29 U.S.C. § 1132(a)(1)(B)

25. Plaintiff repeats and realleges the allegations set forth in paragraphs 1 through 24 of the Complaint as though fully set forth herein.

26. Plaintiff avers this Count to the extent ERISA governs this dispute.

27. Section 502(a)(1), codified at 29 U.S.C. § 1132(a) provides a cause of action for a beneficiary or participant seeking payment under a benefits plan.

28. Plaintiff has standing to seek such relief based on the assignments of benefits obtained by Plaintiff from Patient.

29. Upon information and belief, Defendant acted in a fiduciary capacity in administering any claims determined to be governed by ERISA.

30. Plaintiff is entitled to recover benefits due to Patient under any applicable ERISA plan or policy.

31. As a result, Plaintiff has been damaged and continues to suffer damages in the operation of its medical practice.

COUNT TWO

**BREACH OF FIDUCIARY DUTY AND CO-FIDUCIARY DUTY UNDER 29 U.S.C.
§ 1132(a)(3), 29 U.S.C. § 1104(a)(1) and 29 U.S.C. § 1105 (a)**

32. Plaintiff repeats and realleges the allegations set forth in paragraphs 1 through 31 of the Complaint as though fully set forth herein.

33. 29 U.S.C. § 1132(a)(3)(B) provides a cause of action by a participant, beneficiary, or fiduciary to obtain other appropriate equitable relief (i) to redress such violations or (ii) to enforce any provisions of this subchapter or the terms of the plan.

34. Plaintiff seeks redress for Defendant's breaches of fiduciary duty and/or Defendant's breaches of co-fiduciary duty under 29 U.S.C. § 1132(a)(3), 29 U.S.C. § 1104(a)(1) and 29 U.S.C. § 1105 (a)

35. 29 U.S.C. § 1104(a)(1) imposes a "prudent man standard of care" on fiduciaries.

36. Specifically, a fiduciary shall discharge its duties with respect to a plan solely in the interest of the participants and beneficiaries and (A) for the exclusive purpose of: (i) providing benefits to participants and their beneficiaries; and (ii) defraying reasonable expenses of administering the plan; (B) with the care, skill, prudence, and diligence under the circumstances then prevailing that a prudent man acting in a like capacity and familiar with such matters would use in the conduct of an enterprise of a like character and with like aims; (C) by diversifying the investments of the plan so as to minimize the risk of large losses, unless under the circumstances it is clearly prudent not to do so; and (D) in accordance with the documents and instruments governing the plan insofar as such documents and instruments are consistent with the provisions of this subchapter and subchapter III of this chapter. 29 U.S.C. § 1104(a)(1).

37. 29 U.S.C. § 1105(a) imposes liability for breaches of co-fiduciaries.

38. Specifically, a fiduciary with respect to a plan shall be liable for a breach of fiduciary responsibility of another fiduciary with respect to the same plan in the following circumstances: (1) if he participates knowingly in, or knowingly undertakes to conceal, an act or omission of such other fiduciary, knowing such act or omission is a breach; (2) if, by his failure to comply with section 1104(a)(1) [“prudent man standard of care] of this title in the administration of his specific responsibilities which give rise to his status as a fiduciary, he has enabled such other fiduciary to commit a breach; or (3) if he has knowledge of a breach by such other fiduciary, unless he makes reasonable efforts under the circumstances to remedy the breach. 29 U.S.C. § 1105(a).

39. Here, when Defendant acted to deny payment for the medical bills at issue herein, and when they responded to the administrative appeals initiated by Plaintiff, they were clearly acting as a “fiduciary” as that term is defined by ERISA § 1002(21)(A) because, among other reasons, Defendant acted with discretionary authority or control to deny the payment and to manage the administration of the employee benefit plan at issue as described above.

Here, Defendant breached its fiduciary duties by: (1) failing to issue an Adverse Benefit Determination in accordance with the requirements of ERISA and applicable regulations; (2) participating knowingly in, or knowingly undertaking to conceal, an act or omission of such other fiduciary, knowing such act or omission is a breach; (3) failing to make reasonable efforts under the circumstances to remedy the breach of such other fiduciary, including failing to respond to Plaintiff’s internal appeal; and (4) wrongfully withholding money belonging to Plaintiff.

CLAIM FOR RELIEF

WHEREFORE, Plaintiff demands judgment against Defendant as follows:

- A. For an Order directing Defendant to pay Plaintiff \$138,419.61;
- B. For an Order directing Defendant to pay Plaintiff all benefits Patient would be entitled to under the applicable insurance plan or policy administered by Defendant;
- C. For compensatory damages and interest;
- D. For attorney's fees and costs of suit; and
- E. For such other and further relief as the Court may deem just and equitable.

Dated: New York, NY
February 17, 2021

SCHWARTZ SLADKUS
REICH GREENBERG ATLAS LLP
Attorneys for Plaintiff

By: /s/ Michael Gottlieb
Michael Gottlieb
444 Madison Avenue
New York, New York 10022
(212) 743-7054

EXHIBIT A

IR ANGIO CEREBRAL ARTERY BILATERAL IR EMBOLIZATION NEURO BRAIN OR SPINAL CORD

Status: **Final result**

Imaging Links

PACS Images

Virtual Consult

Signed By

Signed

Date/Time

Phone

Pager

ARCOT, KARTHIKEYAN M

Nov 25, 5:15 PM
2016

718-630-6756

Study Result

PRE OPERATIVE DIAGNOSIS: High-grade symptomatic stenosis of the right common and internal carotid artery for carotid stenting

POST OPERATIVE DIAGNOSIS:

1. Successful endovascular angioplasty and stenting with embolic protection of the high-grade symptomatic stenosis of the right common and internal carotid artery with significant resolution of the previously noted stenosis

PROCEDURE: Angioplasty and stenting of the right common and internal carotid artery with embolic protection

REFERRING PHYSICIAN: Dr. Liff

DATE OF SERVICE: 11/23/2016

SURGEON: Dr. Arcot

CO-SURGEON: Dr. Tiwari

FIRST ASSISTANT: Dr. Selas

CONSENT: Informed consent was obtained for the procedure after discussing the potential risks and benefits of the procedure. Potential risks such as vascular injury, vascular occlusion, further stroke, intracranial hemorrhage and even death were discussed. After all questions were satisfactorily answered, the patient gave informed consent.

ANESTHESIA: General anesthesia

PREOP MEDICATIONS: None

INTRODUCTION: A timeout procedure was documented, the patient's name date of birth and medical record number as well as the procedures to be performed was confirmed by the entire team, after everyone in the room agreed, the procedure continued. After the patient was placed under anesthesia, both groins were prepped and draped in the usual sterile fashion.

██████████ Temuri (MR # 11850718) Printed by Ambooj Tiwari, MD [TIWARA01] at 12/... Page 2 of 5

The right external carotid artery was selected and here the catheter was exchanged for a 9 French sheath and the MOMA device using an exchange length a advantage glide wire wire.

An injection of the right common carotid artery was performed via the MOMA device to confirm placement.

The external carotid balloon segment of the MOMA device was in the external carotid artery. External carotid artery balloon was inflated and the advantage glide wire was carefully withdrawn.

A SYNCHRO 2 wire was then navigated past the stenosis into the petrous internal carotid artery.

A 6 x 40 peripheral balloon was navigated just proximal to the stenosis.

The common carotid artery balloon was inflated and aspiration was turned on.

The balloon was then navigated and positioned across the area of maximal stenosis and inflated under fluoroscopy while aspiration was turned on. There was significant relief of the stenosis and the balloon was deflated.

The balloon was withdrawn. Aspiration was turned off

A 6 x 40 precise stent was navigated just proximal to the stenosis. Aspiration was turned on

The stent was positioned appropriately across the stenosis and deployed. The aspiration was turned off and the pusher was withdrawn.

Aspiration was continued for 30 seconds.

The external carotid artery balloon was deflated.

Aspiration was continued for about 30 seconds.

The common carotid artery balloon was deflated.

Aspiration was continued for a further 30 seconds.

Follow-up angiogram 1:

An injection of the right common carotid artery was performed with cervical views.

It revealed excellent positioning of the stent with significant resolution of the stenosis. There appeared to be mild vasospasm distal to the stent.

Right external carotid artery was occluded by the moma device.

Right common carotid artery appear normal without any significant stenosis.

Follow-up angiogram 2:

Injection of the right common carotid artery was performed with cranial views.

The right internal carotid artery appear normal without any areas of irregularity of stenosis. The right MCA appears normal without any areas of irregularity of stenosis.

The flow is significantly more robust and improved in the territory of the right MCA. The previously noted nonocclusive thrombus is not visualized at this time.

Follow-up angiogram 3:

An injection of the right common carotid artery was performed with cervical views.

It revealed excellent positioning of the stent with significant resolution of the stenosis. There appeared to be mild vasospasm distal to the stent.

Right external carotid artery was occluded by the moma device.

The decision was made to give 5 mg of verapamil intra-arterially at this point and it was injected via the moma device with careful monitoring of blood pressure over 5 minutes.

Right common carotid artery appear normal without any significant stenosis.

Follow-up angiogram 4:

An injection of the right common carotid artery was performed with cervical views.

It revealed excellent positioning of the stent with significant resolution of the stenosis. There was improvement in the spasm distal to the stent.

Right external carotid artery was occluded by the moma device.

The MOMA device was removed.

Right common carotid artery appear normal without any significant stenosis.

The right common femoral artery was selected and injected with pelvic views.

Right common femoral artery, right superficial and deep femoral arteries appear normal without any areas of irregularity of stenosis.

Hemostasis was obtained using a Angio-Seal 8 French device

The patient tolerated the procedure well. There were no complications during the procedure.

Impression:

1. Successful endovascular angioplasty and stenting with embolic protection of the high-grade symptomatic stenosis of the right common and internal carotid artery with significant resolution of the previously noted stenosis

INTRAOPERATIVE MEDICATIONS:

Verapamil

RADIATION DOSE:

AP 22.5 min/ 532.38 mGy

Lat: 20 min/202.65 mGy

MATERIALS UTILIZED:

Diagnostic angiography kit

6 mm x 40 mm precise stent

6 mm x 40 mm Sterling balloon

If you have any questions regarding this procedure or regarding the patient please do not hesitate to contact us at 718-6301270.

Sincerely,

Karthikeyan Arcot, MD
Vascular and Interventional Neurology
Interventional Neuro Associates

Final Report: Dictated by and Signed by Attending Karthikeyan Arcot MD 11/25/2016 5:15 PM

External Result Report

External Result Report

Result History

Order 155869500

IR ANGIO CEREBRAL ARTERY BILATERAL (Order 155672422)

IR EMBOLIZATION NEURO BRAIN OR SPINAL CORD (Order 155869500)

Imaging

Date: **11/23/2016** Department: **Lm 3c** Released By: **Giuseppe T Montagna (auto-released)**
 Authorizing: **Jeremy M Liff, MD**

Order Information

Order Date/Time	Release Date/Time	Start Date/Time	End Date/Time
11/23/16 07:35 PM	11/23/16 07:35 PM	11/23/16 07:45 PM	11/23/16 07:45 PM

Order Questions

Question	Answer	Comment
Reason for exam:	r ica stenosis, stroke	

Note: Enter reason for exam

Order Details

Frequency	Duration	Priority	Order Class
1 time imaging	1 occurrence	Routine	Hospital Performed

Original Order

Ordered On	Ordered By
11/23/2016 7:35 PM	Giuseppe T Montagna

Appointments for this Order

11/23/2016 2:00 PM - 45 min LM NIR RM (Resource) Lm 3 Ir Cardiac Cath Ep

Acknowledgement Info

For	At	Acknowledged By	Acknowledged On
Placing Order	11/23/16 1935	Jessica Lok, RN	11/23/16 2049

Verbal Order Info

Action	Created on	Order Mode	Entered by	Responsible Provider	Signed by	Signed on
Ordering	11/23/16 1935	Verbal with readback	Giuseppe T Montagna	Jeremy M Liff, MD	Jeremy M Liff, MD	11/26/16 1556

Additional Information

Associated Reports
 View Encounter
 Priority and Order Details

Order Requisition

IR EMBOLIZATION NEURO BRAIN OR SPINAL CORD (Order #155869500) on 11/23/16

EXHIBIT B



Jeffrey Farkas MD, LLC DBA Interventional Neuro Associates

ASSIGNMENT OF BENEFITS / ERISA AUTHORIZED REPRESENTATIVE FORM & LIMITED POWER OF ATTORNEY

Assignment of Insurance Benefits - Appointment as Legal Authorized Representative

I hereby irrevocably assign all applicable health insurance benefits and all rights and obligations that I and my dependents have under my health plan to Jeffrey Farkas MD, LLC DBA Interventional Neuro Associates and their chosen affiliated law firms (hereinafter, "My Authorized Representatives") and I appoint them as my authorized representative with the power to:

- File medical claims with the health plan including filing arbitration/litigation in your name on my behalf against the PIP carrier/health care carrier
- File appeals and grievances with the health plan
- Institute any necessary litigation and/or complaints against my health plan naming me as plaintiff in such lawsuits and actions if necessary (or me as guardian of the patient if the patient is a minor).
- Discuss or divulge any of my personal health information or that of my dependents with any third party including the health plan. I authorize you and your attorney to obtain medical information regarding my physical condition from any other health care provider, including hospitals, diagnostic centers, etc., and I specifically authorize such health care providers(s) to release all such information to you about me, including medical reports, x-ray reports, narrative reports, and any other report or information regarding my physical condition.

I certify that the health insurance information that I provided to Provider is accurate as of the date set forth below and that I am responsible for keeping it updated.

I am fully aware that having health insurance does not absolve me of my responsibility to ensure that my bills for professional services from Provider are paid in full. I also understand that I am responsible for all amounts not covered by my health insurance, including co-payments, co-insurance, and deductibles.

Authorization to Release Information

I hereby authorize My Authorized Representatives to: (1) release any information necessary to my health benefit plan (or its administrator) regarding my illness and treatments; (2) process insurance claims generated in the course of examination or treatment; and (3) allow a photocopy of my signature to be used to process insurance claims. This order will remain in effect until revoked by me in writing.

ERISA Authorization

I hereby designate, authorize, and convey to My Authorized Representatives to the full extent permissible under law and under any applicable insurance policy and/or employee health care benefit plan: (1) the right and ability to act as my Authorized Representative in connection with any claim, right, or cause of action including litigation against my health plan (even to name me as a plaintiff in such action) that I may have under such insurance policy and/or benefit plan; and (2) the right and ability to act as my Authorized Representative to pursue such claim, right, or cause of action in connection with said insurance policy and/or benefit plan (including but not limited to, the right and ability to act as my Authorized Representative with respect to a benefit plan governed by the provisions of ERISA as provided in 29 C.F.R. §2560.5031(b)(4) with respect to any healthcare expense incurred as a result of the services I received from Provider and, to the extent permissible under the law, to claim on my behalf, such benefits, claims, or reimbursement, and any other applicable remedy, including fines. I authorize communication with the Provider and his authorized representatives by email and my email address is _____@_____.

I understand I can revoke this authorization in writing at any time. I direct all reimbursable medical payments go directly to you, Jeffrey Farkas MD, LLC, DBA Interventional Neuro Associates, "The Practice". I agree to turn over to "The Practice" any checks I receive on behalf of services rendered to me by the providers at "The Practice" and I am aware such payments do not belong to me. I am aware that if I fail to turn over payments to "The Practice" that have been sent to me on behalf of services rendered to me by "The Practice" and if I attempt to keep and profit from such payments and services "The Practice" and it's legal representatives have the right to consider such profiting equivalent to grand theft and prosecute you as one who committed a felony crime. In the event the insurance carrier responsible for making medical payments in this matter does not accept my assignment, or my assignment is challenged or deemed invalid, I execute this limited/special power of attorney and appoint and authorize your collection attorney as my agent and attorney to collect payment for your medical services directly against the carrier in this case, in my name, including filing an arbitration demand or lawsuit. I specifically authorize that attorney to file directly against that carrier in my name or in your name as a medical provider rendering services to me and designate your collection attorney as my attorney in fact. I further grant limited power of attorney to you as my medical provider to receive and collect directly from the insurance carrier money due you for services rendered to me in this matter, and hereby instruct the insurance carrier to pay you directly any monies due you for medical services you rendered to me. I authorize you and or your attorney to receive from my insurer, immediately upon verbal request, all information regarding last payment made by said insurer on my claim, including date of payment and balance of benefits remaining.

A photocopy of this Assignment Authorization shall be as effective and valid as the original.

SIGNATURE OF PATIENT, PARENT, GUARDIAN OR INDIVIDUAL RESPONSIBLE FOR PAYMENT

DATE

10/31/17

EXHIBIT C



CIGNA - PPO
PO BOX 182223
CHATTANOOGA, TN 37422

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA <input type="checkbox"/>		PICA <input type="checkbox"/>	
1. MEDICARE <input type="checkbox"/> (Medicare #) MEDICAID <input type="checkbox"/> (Medicaid #) TRICARE <input type="checkbox"/> (ID#DOD#) CHAMPVA <input type="checkbox"/> (Member ID#) GROUP HEALTH PLAN <input type="checkbox"/> (ID#) FECA BLK LUNG <input type="checkbox"/> (ID#) OTHER <input checked="" type="checkbox"/> (ID#)		1a. INSURED'S I.D. NUMBER (For Program in Item 1) HCS22718790600	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) [REDACTED] Temuri		3. PATIENT'S BIRTH DATE MM DD YY [REDACTED] SEX M <input checked="" type="checkbox"/> F <input type="checkbox"/>	
4. INSURED'S NAME (Last Name, First Name, Middle Initial) [REDACTED] Temuri		5. PATIENT'S ADDRESS (No., Street) [REDACTED]	
6. PATIENT RELATIONSHIP TO INSURED Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>		7. INSURED'S ADDRESS (No., Street) [REDACTED]	
CITY [REDACTED] STATE NY		CITY [REDACTED] STATE NY	
ZIP CODE [REDACTED] TELEPHONE (Include Area Code) [REDACTED]		ZIP CODE [REDACTED] TELEPHONE (Include Area Code) [REDACTED]	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)		10. IS PATIENT'S CONDITION RELATED TO:	
a. OTHER INSURED'S POLICY OR GROUP NUMBER		a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
b. RESERVED FOR NUCC USE		b. AUTO ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO PLACE (State) _____	
c. RESERVED FOR NUCC USE		c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
d. INSURANCE PLAN NAME OR PROGRAM NAME		10d. CLAIM CODES (Designated by NUCC)	
11. INSURED'S POLICY GROUP OR FECA NUMBER		11. INSURED'S DATE OF BIRTH MM DD YY [REDACTED] SEX M <input checked="" type="checkbox"/> F <input type="checkbox"/>	
a. INSURED'S DATE OF BIRTH MM DD YY [REDACTED] SEX M <input checked="" type="checkbox"/> F <input type="checkbox"/>		b. OTHER CLAIM ID (Designated by NUCC)	
c. INSURANCE PLAN NAME OR PROGRAM NAME CIGNA - PPO		d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO If yes, complete items 9, 9a and 9d.	
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE. I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNED _____ DATE _____		13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED _____	
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP): MM DD YY QUAL _____		15. OTHER DATE MM DD YY QUAL _____	
16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY		17. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM 11 21 16 TO MM DD YY	
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE		18. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO \$ CHARGES	
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC) Corrected claim. Original claim #000056929-CGA		20. RESUBMISSION CODE 7 ORIGINAL REF. NO. 000056929-CGA	
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) A. I67.82 B. _____ C. _____ D. _____ E. _____ F. _____ G. _____ H. _____ I. _____ J. _____ K. _____ L. _____		22. PRIOR AUTHORIZATION NUMBER	
23. DATE(S) OF SERVICE From MM DD YY To MM DD YY B. PLACE OF SERVICE EMG C. D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS I MODIFIER E. DIAGNOSIS POINTER F. \$ CHARGES G. DAYS OR UNITS H. EPSDT Family Plan I. ID. QUAL J. RENDERING PROVIDER ID. #			
1 11 22 16 11 22 16 21 Y 99291 24 a 2200 00 1 NPI 1659638708			
2			
3			
4			
5			
6			
25. FEDERAL TAX I.D. NUMBER 461672913 SSN EIN <input type="checkbox"/> <input checked="" type="checkbox"/>		26. PATIENT'S ACCOUNT NO. 110460041278806	
27. ACCEPT ASSIGNMENT? (For govt. claims, see back.) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		28. TOTAL CHARGE \$ 2200 00 29. AMOUNT PAID \$	
30. Rsvd for NUCC Use		31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) J. Liff 02/28/2018 SIGNED DATE	
32. SERVICE FACILITY LOCATION INFORMATION Lutheran Medical Center INPT 150 55th Street Brooklyn, NY 11220 a. 1659638708 b.		33. BILLING PROVIDER INFO & PH # (201) 387-1957 Jeffrey Farkas MD, LLC DBA Inte 43 Westminster Avenue Bergenfield, NJ 07621 a. 1114267929 b.	

CIGNA - PPO
PO BOX 182223
CHATTANOOGA, TN 37422

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA <input type="checkbox"/>		PICA <input type="checkbox"/>	
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5. PATIENT'S ADDRESS (No., Street) [REDACTED]		6. PATIENT RELATIONSHIP TO INSURED Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>	
7. INSURED'S ADDRESS (No., Street) [REDACTED]		7. INSURED'S ADDRESS (No., Street) [REDACTED]	
CITY [REDACTED] STATE NY		CITY [REDACTED] STATE NY	
ZIP CODE [REDACTED] TELEPHONE (Include Area Code) [REDACTED]		ZIP CODE [REDACTED] TELEPHONE (Include Area Code) [REDACTED]	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)		10. IS PATIENT'S CONDITION RELATED TO:	
a. OTHER INSURED'S POLICY OR GROUP NUMBER		a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
b. RESERVED FOR NUCC USE		b. AUTO ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO PLACE (State) <input type="checkbox"/>	
c. RESERVED FOR NUCC USE		c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
d. INSURANCE PLAN NAME OR PROGRAM NAME		10d. CLAIM CODES (Designated by NUCC)	
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE. I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNED _____ DATE _____		11. INSURED'S POLICY GROUP OR FECA NUMBER a. INSURED'S DATE OF BIRTH MM DD YY [REDACTED] SEX M <input checked="" type="checkbox"/> F <input type="checkbox"/> b. OTHER CLAIM ID (Designated by NUCC) c. INSURANCE PLAN NAME OR PROGRAM NAME CIGNA - PPO d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO If yes, complete items 9, 9a and 9d.	
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP): MM DD YY QUAL _____		15. OTHER DATE MM DD YY QUAL _____	
16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY		17. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM 11 21 16 TO MM DD YY	
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 17a. [REDACTED] 17b. NPI [REDACTED]		18. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO \$ CHARGES	
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC) Corrected claim. Original claim # 000056930-CGA		20. RESUBMISSION CODE 7 ORIGINAL REF. NO. 000056930-CGA	
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 0 A. I67.82 B. _____ C. _____ D. _____ E. _____ F. _____ G. _____ H. _____ I. _____ J. _____ K. _____ L. _____		22. PRIOR AUTHORIZATION NUMBER	
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY B. PLACE OF SERVICE C. EMG D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS I MODIFIER E. DIAGNOSIS POINTER F. \$ CHARGES G. DAYS OR UNITS H. EPSDT Family Plan I. ID. QUAL J. RENDERING PROVIDER ID. #			
1 11 23 16 11 23 16 21 Y 99291 24 a 2200 00 1 NPI 1659638708			
2			
3			
4			
5			
6			
25. FEDERAL TAX I.D. NUMBER 461672913 SSN EIN <input type="checkbox"/> <input checked="" type="checkbox"/>		26. PATIENT'S ACCOUNT NO. 110460041297602	
27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		28. TOTAL CHARGE \$ 2200 00 29. AMOUNT PAID \$ 30. Rsvd for NUCC Use	
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) J. Liff 02/28/2018 SIGNED DATE		32. SERVICE FACILITY LOCATION INFORMATION Lutheran Medical Center INPT 150 55th Street Brooklyn, NY 11220 a. 1659638708 b.	
33. BILLING PROVIDER INFO & PH # (201) 387-1957 Jeffrey Farkas MD, LLC DBA Inte 43 Westminster Avenue Bergenfield, NJ 07621 a. 1114267929 b.			

CIGNA - PPO
PO BOX 182223
CHATTANOOGA, TN 37422

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA		PICA	
1. MEDICARE (Medicare #) <input type="checkbox"/> MEDICAID (Medicaid #) <input type="checkbox"/> TRICARE (ID#DOD#) <input type="checkbox"/> CHAMPVA (Member ID#) <input type="checkbox"/> GROUP HEALTH PLAN (ID#) <input type="checkbox"/> FECA BLK LUNG (ID#) <input type="checkbox"/> OTHER (ID#) <input checked="" type="checkbox"/>		1a. INSURED'S I.D. NUMBER (For Program in Item 1) HCS22718790600	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) [REDACTED] Temuri		3. PATIENT'S BIRTH DATE (MM DD YY) [REDACTED] M <input checked="" type="checkbox"/> F <input type="checkbox"/>	
5. PATIENT'S ADDRESS (No., Street) [REDACTED]		6. PATIENT RELATIONSHIP TO INSURED Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>	
7. INSURED'S ADDRESS (No., Street) [REDACTED]		7. INSURED'S ADDRESS (No., Street) [REDACTED]	
CITY [REDACTED] STATE NY		CITY [REDACTED] STATE NY	
ZIP CODE [REDACTED] TELEPHONE (Include Area Code) [REDACTED]		ZIP CODE [REDACTED] TELEPHONE (Include Area Code) [REDACTED]	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)		10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO b. AUTO ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO PLACE (State) <input type="checkbox"/> c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
a. OTHER INSURED'S POLICY OR GROUP NUMBER		11. INSURED'S POLICY GROUP OR FECA NUMBER	
b. RESERVED FOR NUCC USE		a. INSURED'S DATE OF BIRTH (MM DD YY) [REDACTED] M <input checked="" type="checkbox"/> F <input type="checkbox"/>	
c. RESERVED FOR NUCC USE		b. OTHER CLAIM ID (Designated by NUCC)	
d. INSURANCE PLAN NAME OR PROGRAM NAME		c. INSURANCE PLAN NAME OR PROGRAM NAME CIGNA - PPO	
10d. CLAIM CODES (Designated by NUCC)		d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO If yes, complete items 9, 9a and 9d.	
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE. I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNED _____ DATE _____		13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED _____	
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP): MM DD YY QUAL _____		15. OTHER DATE MM DD YY QUAL _____	
16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY		17. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM 11 21 16 TO MM DD YY	
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 17a. [REDACTED] 17b. NPI [REDACTED]		18. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO \$ CHARGES	
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)		20. RESUBMISSION CODE ORIGINAL REF. NO.	
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 0 A. I63.231 B. I67.848 C. I67.82 D. _____ E. _____ F. _____ G. _____ H. _____ I. _____ J. _____ K. _____ L. _____		22. PRIOR AUTHORIZATION NUMBER	
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY B. PLACE OF SERVICE C. EMG D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS I MODIFIER E. DIAGNOSIS POINTER F. \$ CHARGES G. DAYS OR UNITS H. EPSDT Family Plan I. ID. QUAL J. RENDERING PROVIDER ID. #			
1 11 23 16 11 23 16 21 Y 37215 a 33000 00 1 NPI 1609198779			
2 11 23 16 11 23 16 21 Y 36223 59 c 32000 02 1 NPI 1609198779			
3 11 23 16 11 23 16 21 Y 36226 59 c 32000 00 1 NPI 1609198779			
4 11 23 16 11 23 16 21 Y 61650 59 b 20000 00 1 NPI 1609198779			
5 11 23 16 11 23 16 21 Y 36245 59 c 5125 00 1 NPI 1609198779			
6 11 23 16 11 23 16 21 Y 75898 26 59 a 3600 00 1 NPI 1609198779			
25. FEDERAL TAX I.D. NUMBER 461672913 SSN EIN <input type="checkbox"/> <input checked="" type="checkbox"/>		26. PATIENT'S ACCOUNT NO. 065702042605562	
27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		28. TOTAL CHARGE \$ 125725 02 29. AMOUNT PAID \$ 30. Rsvd for NUCC Use	
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) A. Tiwari 02/28/2018 SIGNED DATE		32. SERVICE FACILITY LOCATION INFORMATION Lutheran Medical Center INPT 150 55th Street Brooklyn, NY 11220 a. 1609198779 b.	
		33. BILLING PROVIDER INFO & PH # (201) 387-1957 Jeffrey Parkas MD, LLC DBA Inte 43 Westminster Avenue Bergenfield, NJ 07621 a. 1114267929 b.	



CIGNA - PPO
PO BOX 182223
CHATTANOOGA, TN 37422

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA <input type="checkbox"/>		PICA <input type="checkbox"/>	
1. MEDICARE <input type="checkbox"/> (Medicare #) MEDICAID <input type="checkbox"/> (Medicaid #) TRICARE <input type="checkbox"/> (ID#DOD#) CHAMPVA <input type="checkbox"/> (Member ID#) GROUP HEALTH PLAN <input type="checkbox"/> (ID#) FECA BLK LUNG <input type="checkbox"/> (ID#) OTHER <input checked="" type="checkbox"/> (ID#)		1a. INSURED'S I.D. NUMBER (For Program in Item 1) HCS22718790600	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) [REDACTED] Temuri		3. PATIENT'S BIRTH DATE MM DD YY [REDACTED] SEX M <input checked="" type="checkbox"/> F <input type="checkbox"/>	
5. PATIENT'S ADDRESS (No., Street) [REDACTED]		6. PATIENT RELATIONSHIP TO INSURED Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>	
7. INSURED'S ADDRESS (No., Street) [REDACTED]		8. RESERVED FOR NUCC USE	
CITY [REDACTED] STATE NY		CITY [REDACTED] STATE NY	
ZIP CODE [REDACTED] TELEPHONE (Include Area Code) [REDACTED]		ZIP CODE [REDACTED] TELEPHONE (Include Area Code) [REDACTED]	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)		10. IS PATIENT'S CONDITION RELATED TO:	
a. OTHER INSURED'S POLICY OR GROUP NUMBER		a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
b. RESERVED FOR NUCC USE		b. AUTO ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO PLACE (State) <input type="checkbox"/>	
c. RESERVED FOR NUCC USE		c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
d. INSURANCE PLAN NAME OR PROGRAM NAME		10d. CLAIM CODES (Designated by NUCC)	
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE. I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNED _____ DATE _____		11. INSURED'S POLICY GROUP OR FECA NUMBER a. INSURED'S DATE OF BIRTH MM DD YY [REDACTED] SEX M <input checked="" type="checkbox"/> F <input type="checkbox"/> b. OTHER CLAIM ID (Designated by NUCC) c. INSURANCE PLAN NAME OR PROGRAM NAME CIGNA - PPO d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO If yes, complete items 9, 9a and 9d.	
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP): MM DD YY QUAL		15. OTHER DATE QUAL MM DD YY	
16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY		17. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM 11 21 16 TO MM DD YY	
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 17a. <input type="checkbox"/> 17b. NPI		18. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO \$ CHARGES	
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)		22. RESUBMISSION CODE ORIGINAL REF. NO.	
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) A. I63.231 B. I67.848 C. I67.82 D. <input type="checkbox"/> E. <input type="checkbox"/> F. <input type="checkbox"/> G. <input type="checkbox"/> H. <input type="checkbox"/> I. <input type="checkbox"/> J. <input type="checkbox"/> K. <input type="checkbox"/> L. <input type="checkbox"/> ICD Ind. 0		23. PRIOR AUTHORIZATION NUMBER	
24. A. DATE(S) OF SERVICE From To B. PLACE OF SERVICE C. EMG D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER E. DIAGNOSIS POINTER F. \$ CHARGES G. DAYS OR UNITS H. EPSDT Family Plan I. ID. QUAL J. RENDERING PROVIDER ID. #			
1 11 23 16 11 23 16 21 Y 75898 26 59 a 3600 00 1 NPI 1609198779			
2 11 23 16 11 23 16 21 Y 75898 26 59 a 3600 00 1 NPI 1609198779			
3 11 23 16 11 23 16 21 Y 75898 26 59 a 3600 00 1 NPI 1609198779			
4 11 23 16 11 23 16 21 Y 75736 26 59 c 1250 00 1 NPI 1609198779			
5			
6			
25. FEDERAL TAX I.D. NUMBER SSN EIN 461672913 <input type="checkbox"/> <input checked="" type="checkbox"/>		26. PATIENT'S ACCOUNT NO. 065702042605562	
27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		28. TOTAL CHARGE \$ 12050 00	
29. AMOUNT PAID \$		30. Rsvd for NUCC Use	
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) A. Tiwari SIGNED _____ DATE 02/28/2018		32. SERVICE FACILITY LOCATION INFORMATION Lutheran Medical Center INPT 150 55th Street Brooklyn, NY 11220 a. 1609198779 b.	
33. BILLING PROVIDER INFO & PH # (201) 387-1957 Jeffrey Farkas MD, LLC DBA Inte 43 Westminster Avenue Bergenfield, NJ 07621 a. 1114267929 b.			

EXHIBIT D



[CC]

Provider Remittance Summary

Forwarding Service Requested

JEFFREY FARKAS MD, LLC DBA I
43 WESTMINSTER AVENUE
BERGENFIELD NJ 07621

5

Customer Care Information

If you have any questions regarding this claim,
please contact the Fund Office at
1-888-721-2128

Group: HCS
Group #: LEA006003

Date: 05/19/2017
Patient Acct #: 065702042605562

Claim #: 000067123-CGA

Provider: AMBOOJ TIWARI

Patient: TEMURI, [REDACTED]

Enrollee: TEMURI, [REDACTED]

Enrollee ID: HCS227187906

	Dates of Service	Procedure Code	Charged Amount	Not Covered	Reason Code	Provider Discount	Allowable Amount	Deductible Amount	Co-Pay Amount	Co-Insurance	Payment Amount
001	11/23-11/23/2016	37215	\$33,000.00	\$0.00	755	\$31,639.97	\$1,360.03	\$0.00	\$0.00	\$0.00	\$1,360.03
002	11/23-11/23/2016	36223	\$32,000.02	\$0.00	755	\$31,699.98	\$400.04	\$0.00	\$0.00	\$0.00	\$400.04
003	11/23-11/23/2016	36226	\$32,000.00	\$0.00	755	\$31,546.03	\$453.97	\$0.00	\$0.00	\$0.00	\$453.97
004	11/23-11/23/2016	61650	\$20,000.00	\$0.00	755	\$18,524.58	\$1,475.42	\$0.00	\$0.00	\$0.00	\$1,475.42
005	11/23-11/23/2016	36245	\$5,125.00	\$0.00	755	\$4,819.04	\$305.96	\$0.00	\$0.00	\$0.00	\$305.96
006	11/23-11/23/2016	75898	\$3,600.00	\$0.00	755	\$3,500.87	\$99.13	\$0.00	\$0.00	\$0.00	\$99.13
007	11/23-11/23/2016	75898	\$3,600.00	\$0.00	755	\$3,500.87	\$99.13	\$0.00	\$0.00	\$0.00	\$99.13
008	11/23-11/23/2016	75898	\$3,600.00	\$0.00	755	\$3,500.87	\$99.13	\$0.00	\$0.00	\$0.00	\$99.13
009	11/23-11/23/2016	75898	\$3,600.00	\$0.00	755	\$3,500.87	\$99.13	\$0.00	\$0.00	\$0.00	\$99.13
010	11/23-11/23/2016	75736	\$1,250.00	\$0.00	755	\$1,181.85	\$68.15	\$0.00	\$0.00	\$0.00	\$68.15
Column Totals			\$137,775.02	\$0.00		\$133,314.93	\$4,460.09	\$0.00	\$0.00	\$0.00	\$4,460.09

Patient's Responsibility: \$0.00

Other Carrier Adjustment \$0.00
Total Payment Amount \$4,460.09

Procedures

Code	Description
36223	PLACE CATH CAROTID/INOM ART
36226	PLACE CATH VERTEBRAL ART
36245	INS CATH ABD/L-EXT ART 1ST
37215	TRANSCATH STENT CCA WEPS
61650	EVASC PRLNG ADMN RX AGNT 1ST
75736	ARTERY X-RAYS PELVIS
75898	FOLLOW-UP ANGIOGRAPHY

Remarks

Code	Description
755	THE AMOUNT REPRESENTS THE DIFFERENCE BETWEEN THE PROVIDER'S CHARGES AND THE OUT OF NETWORK ALLOWED AMOUNT. THE MEMBER IS RESPONSIBLE FOR THIS AMOUNT.

Payment Details

Paid To	Check Date	Amount
JEFFREY FARKAS MD, LLC DBA I	05/19/17	\$4,460.09

Additional Information

We have selected Pay-Plus Solutions as our ePayment vendor to assist us in quickly transferring payment as well as complying with PPACA Section 1104. To sign up for ePayments using ACH or Credit Card, as well as electronic EOB's (835, Excel, PDF) please visit www.PPSONLINE.COM, email membership@ppsonline.com, or call Pay-Plus' Membership Services at 1-877-828-8834.